RIVER VALLEY
DENTISTRY

Patient Information

Patient Name_____ Date of Birth_____

Driver's License #_____ Social Security #_____

Parent's Name (if minor)_____

Address_____ City/State/Zip_____

_____Married _____Single _____Widowed _____Divorced ____ Separated

Telephone: Home _____Work_____ Cell_____

Email _____

Employed By _____Student/School_____

Spouses Name_____ Spouses Employer_____

Who is responsible for your bill _____

Dental Insurance: Yes_____No_____ Insurance Company Name_____

Person Carrying Insurance _____

Social Security #_____ Date of Birth_____

Secondary Insurance: Yes____No____ Insurance Company Name_____

Person Carrying Insurance_____

Social Security #_____Date of Birth_____

Whom may we thank for referring you to us? _____

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Financial Policy

Payment is expected at the time services are rendered unless prior arrangements have been made.

I consent to treatment necessary or desirable to that first patient above. I also acknowledge full responsibility for the patient of such services and agree to pay for them in full at the time services are rendered.

I understand filing my insurance is a courtesy but I am responsible for the payment due. I further agree that in the event of non-payment, my account may be placed with an attorney or a collection agency that I will pay and be responsible for all legal costs and charges included but not limited to reasonable attorney fees, court cost, disbursements and collection agency charges incurred by Dr. Hammontree. I hereby waive demand notice protest of non-payment.

Signature_____Date_____

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Financial Agreement

Thank you for choosing River Valley Dentistry for your dental health needs.

We do not want finances to be an issue for our patients. We understand that it is not always possible to pay your dental bill in full, so we would like to explain our financial options. Please choose the option that works best for you.

1. Monthly payment options – If you need to make long-term payments, we can offer financing with Care-Credit, which offers up to 12 months NO INTEREST as well as longer terms with low interest rates. You must qualify for this option. Please do not hesitate to ask us about this option. We may conveniently qualify you right here in the office today.

2. We can offer a 4 month payment plan with credit card on file for treatment over $500.

Dental Insurance

As a courtesy to you, we will complete your insurance form and submit it to the insurance company. Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided. If you fail to bring the required insurance information to your appointment, we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.

_____(please initial)

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Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

Minor Patients

The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid.

Returned checks

A fee of $35.00 will be charged for any returned checks.

Broken Appointments

There is a high demand for appointments in our office. When we schedule an appointment we are reserving time with our doctor, assistant, or hygienist. We try not to double book in our office so that each patient can get the attention they deserve. When a patient cancels or no shows for an apointment, time is lost that could have been used to help another patient. We ask that patient give us 48 hours notice when having to reschedule. We do understandt hat things happen which are out of your control. These situations will be handled on a case to case basis. The cancellation fee in our office is **$30** when cancelled inside of a 24 hours notice.

_____(please initial)

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I assign directly to River Valley Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand hat I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. River Valley Dentistry may use my health care information and may disclose such information to the above – named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees, and any other charges incurred to collect this account. Additionally, by signing this form, I authorize River Valley Dentistry to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

Thank you for giving us the opportunity to serve your dental needs. If you have any questions about this form, please let us know.

Patient _____

Witness (staff member) _____

Date_____

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Patient Photo Release Form

I _____, hereby authorize River Valley Dentistry, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

Signed_____ Date_____